State of Washington
Department of
Labor and Industries

PROVIDER BULLETIN

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THIS ISSUE

Payment for Job Analysis Review

TO:

Medical Doctors
Chiropractic Physicians
Osteopathic Physicians
Podiatrists
Optometrists
Naturopathic Physicians
Dentists
IME Panels
Vocational Rehabilitation Counselors
Physical & Occupational Therapists
Self Insured Employers

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Purpose

This Provider Bulletin corrects and replaces Provider Bulletin 98-07. Please discard that Bulletin and use this one. The only changes are in the "Review of Job Offers and Job Analysis" section.

This Provider Bulletin pertains to Payment for Job Analysis Review by Attending Doctor and Completion of the Attending Physicians Final Report form. This Provider Bulletin applies to both State Fund and Self-Insured claims.

The information in this bulletin describes new payment policies and billing codes for attending doctors' review of job analyses and completion of the attending doctors' final report form. The billing codes and payment policies described in this bulletin remain **effective for services on and after July 1, 1998.**

Background

Attending doctors are asked to complete various forms and reports for their workers compensation patients. Some of these forms or reports have distinct local codes and descriptions, while others have been billed under the CPT code 99080 "Special reports such as insurance forms."

Some of the services discussed in this bulletin were previously billed under CPT code 99080. In the State Fund payment system, payment for code 99080 is limited to one unit per day per claim per provider. However, some services can be performed more than one time per day or in addition to another service also described by code 99080, such as a "sixty-day narrative report." Therefore, new and revised local codes have been implemented to more properly identify and pay for these services.

Review of Job Offers and Job Analyses

What is the difference between a job offer and a job analysis?

Job Offer – A job offer is an employer's written statement about a specific job the employer is offering to a worker. It is a request for a worker to return to work at a job ***other than*** the job of injury. A job offer is NOT a request from the employer for a ***release for work*** so the worker can return to his or her usual or modified job duties. The attending doctor should NOT bill codes 1038M or 1028M for a release to return to the worker's usual or modified work.

A job offer must include a job description but it **does not** need to include a job analysis.

Job Analysis – A job analysis is a **detailed** evaluation of a specific job or type of job. This job may or may not be offered to the worker and it may or may not be linked to a specific employer. A job analysis is used during vocational services to help determine the types of jobs a worker could reasonably perform considering the worker's skills, work experience and physical limitations.

A job analysis may be included as the job description portion of a job offer, but a job analysis is **not required** in a job offer.

JOB OFFERS

What basic information is included in a job offer?

A job offer should contain:

- A job title.
- A description of the job tasks required. (See note below.) The job description must be in terms that will enable the physician to relate the physical activities of the job to the worker's disability. (RCW 51.32.090[4])
- The work schedule.
- The physical requirements of the job (e.g. frequency of lifting, standing, bending, sitting, etc.)
- Any other related information.
- Proposed start date.

NOTE: A formal job analysis may be provided as the job description required above, but a formal job analysis is **not required** as part of a job offer.

Who prepares job offers?

Job offers are prepared for the attending doctor's review by the injured worker's employer of record (the employer on the date of injury) or the employer's representative. The employer's representative may be a vocational rehabilitation counselor (VRC) or third party administrator (TPA).

Only reviews of job offers from the employer of record or their representative will be paid. Reviews of job offers from other sources are not payable.

What is the attending doctor's responsibility for review of job offers?

Under the provisions of RCW 51.32.090 (4), job offers (including job analyses) must be reviewed by the injured worker's attending doctor. The attending doctor must indicate to the worker and the employer whether or not the worker can physically perform the job.

JOB ANALYSES

What basic information is contained in a job analysis?

A job analysis should include:

- Job title
- The activities and functions required to perform the job, including the physical requirements to perform the duties
- How the work is done (methods, techniques or work process, including devices or materials used)
- Results of the work (goods or services produced)
- Worker skills, knowledge, abilities and adaptations needed to perform the job tasks.
- A description of the work site and individual job site(s).
- The extent of the worker's discretion, responsibility or accountability.
- Other related information.

Who prepares job analyses?

Job analyses reports may be prepared by:

- A VRC as part of the vocational evaluation process described in RCW 51.32.095.

OR

- A physical or occupational therapist at the request of the VRC or employer. (Therapists may bill code V0823 for performing job analyses services.)

OR

- The employer of record or their staff or TPA.

What is the attending doctor's responsibility for review of job analyses?

Job analyses are a critical part of the vocational rehabilitation evaluation process. They assist the VRC, worker and insurer in making decisions about vocational options and benefits.

The attending doctor is responsible for advising the vocational counselor, worker and insurer regarding the worker's ability to physically perform job duties described in each job analysis sent for the doctor's review.

REQUESTS FOR VOCATIONAL INFORMATION

How should requests for information from VRC's and employers be handled?

VRC's or employers may ask the attending doctor to complete physical capacities estimates, supply copies of existing records or reports and to furnish specific information regarding the worker's medical status and/or ability to participate in vocational activities.

WAC 296-18A-480 requires the attending doctor to maintain open communication with the assigned VRC. This includes responding in a timely manner to requests for information and making estimates of the worker's physical restrictions or capacities.

Copies of existing records

Persons requesting copies of existing records should be referred to the insurer to obtain needed copies.

Physical capacities estimates

Physical capacities estimates may be completed and sent to the VRC or employer. Either code 1037M (for employers) or 1048M (for insurer or VRC) may be billed to the insurer.

Requests for reports or specific information

Attending doctors should respond directly to VRC's or employer's requests for specific information regarding the worker's ability to participate in vocational activities. The insurer may be billed code 99080.

COMPLETION OF ATTENDING PHYSICIAN'S FINAL REPORT

What is the Physician's Final Report (PFR)?

The PFR is a form letter sent to attending doctors by the insurer. It may vary in format based upon the insurer. The PFR will request information about:

- The current status of the injured worker's treatment.
- Whether the claim appears ready for closure.
- Whether there is any permanent impairment due to the injury.
- Whether the attending doctor is willing to rate impairment.

When and to whom is the PFR code payable?

The PFR is payable only to the attending doctor and only when requested by the insurer. The code is **not payable** in addition to office visit services on the same day.

PAYMENT POLICIES

The information listed below applies to the services described in this bulletin:

- Job offers and JA reviews
- Physician's Final Report
- VRC's request for specific information
- Physician's Estimate of Physical Capacities

Is prior authorization required?

No prior authorization is required, but services must be requested in order to be payable. Copies of the request and/or completed forms should be retained in the patient file to document the request.

Who may request these services?

Various parties may request these services:

- The Department of Labor and Industries (DLI) as the state fund
- The State Fund employer of record
- The Self-Insured employer of record
- A vocational rehabilitation counselor (VRC) for the employer or insurer.
- A Third Party Administrator (TPA) for the employer (either state fund or Self- Insured).

To whom are completed forms and bills sent?

Based on the requesting party, bills and completed forms should be sent as follows:

Requester	Completed form sent to:	Billing sent to:
DLI or VRC for DLI	Requester	DLI
State Fund employer or TPA	State Fund Employer	DLI
Self-Insured employer	Self-Insured employer	Self-Insured employer*
Self-Insured VRC or TPA	Requester	Self-Insured employer*

**Bills submitted to the State Fund for Self-Insured claims will be denied.*

Who may be compensated for review of job offers or job analyses?

Codes 1038M and 1028M are payable only to the attending doctor for review of job offers or job analyses. Review of job offers and job analyses are payable in addition to other services performed on the same day for the same patient by the same provider.

The opinion of the attending doctor, consultant or an Independent Medical Examiner (IME) regarding whether the worker can perform the job duties described in job offers or job analyses can be used to make claim decisions.

IME fees include the review of records. When job analyses are part of the file record, no additional fee is payable. If job analyses are sent to an IME provider after the completion of the IME, the IME fee for an addendum report may be paid.

The attending doctor may ask other providers, including consultants, to evaluate a patient and review the job analyses. However, the review of the job analyses in these situations is part of the record review included in the evaluation service and is not separately payable to other providers.

Can I bill the insurer for any of these services requested by other parties?

No. You may not bill the insurer for these codes or services when performed at the request of parties not specifically detailed in above. For example, no payment will be made for these codes or services when requested by attorneys or injured workers.

How will these services be coded and paid?

These codes are payable **only** to the attending doctor.

Code	Description	Limits	Fee *
1038M	Review of job offer or analyses (JA) by attending doctor performed at the request of the insurer or state fund employer. Job offer review includes review of job analysis. **First job offer or job analysis reviewed per day.**	Paid once per request.	$25.64 per day
1028M	Review of job offer or analysis (JA) by attending doctor at the request of the insurer or state fund employer. **Each additional job offer or job analyses reviewed on same day.**	Maximum of 5 paid per request. Indicate actual number of requests reviewed in "units" box on bill form.	$12.82 each
1026M	Attending physician final report form completed at request of insurer.	Paid once per request. Not payable in addition to office visits on same day.	$25.64
1037M	Provide physical capacity or restriction information to **state fund** employer	One per request	$16.36
1048M	Completion of Doctor's Estimate of Physical Capacities form	One per request	$16.36
99080	Request for specific information received from VRC	One per request	$25.64

*Fee is subject to change with fee schedule revisions. Check current fee schedule.

For audit purposes, the patient's chart notes must reflect the service provided, date and name of requester. Retaining a copy of the supplied information will also document your records.